at the lower angle of the incision, which was closed to this point. The patient made an excellent recovery and has since had normal bowel function. At no time did she pass fæcal matter in any other way than per anum.—*Johns Hopkins Hospital Bulletin*, February, 1895.

EXTREMITIES.

Direct Digital Compression of the Common Iliac Vessels in Disarticulation of the Hip. By M. CHALOT (Toulouse). The author has devised a method of disarticulation of the hip-joint by means of which the danger of hæmorrhage is reduced to the same degree as in other amputations. A button-hole incision is first made through the abdominal parietes just inside of the anterior superior spine of the ilium; the peritoneum is stripped up and pushed aside, and the fingers are passed beneath this reflected layer as far as the angle formed by the psoas muscle and the sacral promontory; there the termination of the common iliac artery is found and compressed. The disarticulation can then be done in whatever manner is deemed best under the circumstances. It should be remembered that the upper end of the divided femoral vein may bleed from reflux, notwithstanding the fact that the common iliac vein be compressed at the same time as the artery.

Chalot carried out this plan in the case of a man, twenty-one years of age, who was suffering from an encephaloid sarcoma involving the fleshy part of the thigh. The execution was easy, and the patient was cured.—*Transactions of the French Congress of Surgery*, 1894.

HENRY P. DE FOREST (Brooklyn).

MALE GENITO-URINARY ORGANS.

I. The Diagnosis and Treatment of Malignant Tumors of the Kidneys in Adults. By Dr. THORKILD ROVSING (Copenhagen). Since the first malignant tumor of the kidney was removed by Kocher, eighteen years ago, the operation has been done 150 times, with a mortality from the operation of 50 to 66 per cent.

before 1890, and a mortality of 20 to 25 per cent. since then. Wagner has found seventeen cases which have lived a year or more after the operation, but many of these have died of recurrence at a subsequent date. The large mortality has been due to the fact that the diagnosis was not made early enough, and the operation was undertaken when the tumor had reached a large size and formed numerous adhesions. The early diagnosis of these tumors is a chapter which surgeons have neglected.

Clinically the tumors may be divided into the following three groups:

(1) Cases in which a palpable tumor is the first and only symptom. Cases of this kind are not rare, but the diagnosis during the early stages is difficult or impossible. The tumor usually begins in the suprarenal capsule or the upper part of the kidney and reaches a large size before it is discovered, moreover, they may be mistaken for multilocular cystoma, a condition in which operation is contra-indicated, as both kidneys are affected.

(2) Cases with hæmatinuria and a palpable tumor. Typical cases of this kind are easy to diagnose, but they are rare. They are frequently complicated with attacks of renal colic, the urine contains a large quantity of inorganic matter and crystals, making the differential diagnosis from nephrolithiasis very difficult, especially as the kidney is also enlarged in that disease.

(3) Cases of hæmatinuria without a palpable tumor. The early diagnosis presents great difficulties, but it is of the utmost importance, as tumors of this class are usually operable. Hæmorrhage from the bladder can be excluded in that the blood is more intimately mixed with the urine, and instruments passed into the bladder cause no fresh hæmorrhage. The diagnosis is best made by the microscope, as the urine deposits a layer of yellowish-gray granular matter composed largely of round or spindle cells which have undergone fatty degeneration.

The means which we have for diagnosing these tumors are as follows:

(1) A careful family and personal history of the patient. If the patient have a tubercular diathesis one would think of a beginning tuberculosis of the kidney. A rheumatic diathesis or previous attacks of renal colic would indicate nephrolithiasis.

(2) Microscopic examination of the urine is of importance indirectly in that tuberculosis and nephrolithiasis can be diagnosed or excluded; and directly in that the tumor-cells are frequently found.

(3) Palpation is of but little value except in those cases in which the tumor begins in the lower end of the kidney. The healthy kidney sometimes hypertrophies, owing to increased functional activity, and might easily be mistaken for a tumor.

(4) The use of the cystoscope is very limited. It can be of use only in cases of hæmatinuria when the hæmorrhage is not so profuse that it makes the fluid in the bladder opaque before the ureters can be found, and even if we see blood coming from one ureter we are not sure that it is not caused by hyperæmia of the healthy kidney.

(5) The last resort is an exploratory incision which should be made in the lumbar region. The kidney can be more carefully examined than by the abdominal incision, and statistics show a smaller mortality after removal. If the kidney be found normal, the wound may be closed and the other kidney examined or removed.—*Archiv für klinische Chirurgie*, Band. XLIX, Heft 2.

GEORGE R. WHITE (New York).

II. Catheterization of the Male Ureters. By DR. MAX NITZE (Berlin). It has been proven fairly easy to catheterize the female ureters, as Pawlik and Kelly have shown.

In man the case is different. Brenner, Poirier, and Boiseau du Rocher have not been able by their methods to catheterize the male ureter with any degree of certainty.

We can see the mouths of the ureters so clearly with the cystoscope that it seems as though it would be very easy to introduce an instrument under the guidance of the cystoscope. In the woman, when a small sound is carried in alongside of the cystoscope, it is